Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DARYL DANIEL MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Carrier's Austin Representative Box
Box Number 19

Respondent Name
ZENITH INSURANCE CO

MFDR Date Received
January 18, 2012

MFDR Tracking Number
M4-11-4170-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED, EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon further review, Zenith Insurance agrees to pay an additional $150.00 per the fee guidelines in order to resolve this dispute. Here is the breakdown of the payment: 99456 W5 WP - $350 MMI, $300 ROM; Spine, $150 Upper Extremity; Shoulder, $150 DRE, 99456 MI- $50 = $1000.00. Please find attached, the explanation of benefits/EOB showing payment of $1000.00 to Daryl Daniel, MD. Therefore, we feel the dispute has been resolved…"

Response Submitted by: Zenith Insurance Company, 1390 Main Street, Sarasota, FL 34236-5642

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2011	99456-W5-WP	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 8, 2011

- A5W – W1 – PAID IN ACCORDANCE WITH STATE FEE SCHEDULE/REASONABLE GUIDELINES.
- W1 – Workers' Compensation State Fee Schedule Adjustment
- EAR, NOSE, FACE, AND HEAD INJURIES ARE ALL INCLUDED TOGETHER AS ONE BODY AREA FOR IMPAIRMENT RATING. SHOULDER AND BICEP ARE INCLUDED TOGETHER FOR THE SECOND BODY AREA IMPAIRMENT RATING. CHARGES HAVE BEEN PAID ACCORDINGLY FOR TWO BODY AREA IMPAIRMENT RATING AND MMI EXAM.

Explanation of benefits dated June 28, 2011
- A5W – W1 – PAID IN ACCORDANCE WITH STATE FEE SCHEDULE/REASONABLE GUIDELINES.
- W1 – Workers' Compensation State Fee Schedule Adjustment
- Upon further review we are not recommending additional payment. This has been paid per fee schedule.

Explanation of benefits dated July 28, 2011
- A5W – W1 – PAID IN ACCORDANCE WITH STATE FEE SCHEDULE/REASONABLE GUIDELINES.
- W1 – Workers' Compensation State Fee Schedule Adjustment

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $1,250.00 for CPT code 99456-W5-WP with 5 (five) units in Box 24g of the CMS-1500 for a Division ordered Designated Doctor Examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The Division order on the EES14 and DWC032 was to determine Maximum Medical Improvement/Impairment Rating (MMI/IR). The Division ordered the Designated Doctor to rate the upper extremities (bilateral shoulders) and the ears, face, nose and cheekbone (nose, throat and related structures). An additional line item was also billed with CPT code 99456-MI representing multiple impairments for $50.00. The respondent paid CPT code 99456-MI, therefore this CPT code is not in dispute. The Division DWC032 form requested rating the compensable body areas: (1) Laceration-left ear; (2) broken nose; (3) fracture left cheekbone; (4) Contusion left shoulder, right shoulder, right bicep and (5) multiple lacerations to the face. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions are reviewed.

   Per 28 Texas Administrative Code §134.204 the reimbursement is as follows:

   CPT code 99456-W5-WP: Per 28 Texas Administrative Code §134.204(j)(4)(C) the Maximum Allowable Reimbursement (MAR) for the billing and reimbursement of a Maximum Medical Improvement (MMI) evaluation is $350.00.

   CPT code 99456-W5-WP: Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) the Maximum Allowable Reimbursement (MAR) for the billing and reimbursement of an impairment rating of the compensable bilateral shoulders (upper extremities (1st musculoskeletal body area) using the Range of Motion (ROM) method is $300.00.

   CPT code 99456-W5-WP: Per 28 Texas Administrative Code §134.204(j)(4)(D)(i)(II) the Maximum Allowable Reimburement (MAR) for the billing and reimbursement of an impairment rating of the compensable head (face, ear, nose, cheekbone) (2nd non-musculoskeletal) area using the Range of Motion (ROM) method is $150.00.

   Review of the submitted documentation finds only 2 compensable areas were rated therefore, the combined MAR for the MMI and 2 units for the IR areas is $800.00.

2. The respondent has previously reimbursed the requestor the amount of $1,000.00 for the disputed CPT code 99456-W5-WP. The requestor is due a recommended reimbursement in the amount of $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 27, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.